Axel & Associates, Inc.

MANAGEMENT CONSULTANTS

by FedEX

December 27, 2017

Ms. Courtney Avery
Administrator
Illinois Health Facilities and
Services Review Board
525 West Jefferson
Springfield, IL 62761

Dear Courtney:

Enclosed please find two copies of a Certificate of Exemption application addressing the discontinuation of the 28-bed long term care category of service at Alton Memorial Hospital. Also enclosed is a check, in the amount of $2,500.00, as a filing and review fee.

Should any additional information be required, please do not hesitate to contact me.

Sincerely,

Jacob M. Axel
President

enclosures

675 North Court, Suite 210
Palatine, Illinois 60067

Phone (847) 776-7101
Fax (847) 776-7004

E-081-17 ORIGINAL

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR EXEMPTION PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

RECEIVED
DEC 28 2017
HEALTH FACILITIES & SERVICES REVIEW BOARD

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Alton Memorial Hospital	
Street Address:	One Memorial Drive	
City and Zip Code:	Alton, IL 62002	
County: Madison	Health Service Area 11	Health Planning Area: F-01

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name:	Alton Memorial Hospital
Street Address:	One Memorial Drive
City and Zip Code:	Alton, IL 62002
Name of Registered Agent:	Illinois Corporation Service
Registered Agent Street Address:	801 Adlai Stevenson Drive
Registered Agent City and Zip Code:	Springfield, IL 62703
Name of Chief Executive Officer:	David Braasch
CEO Street Address:	One Memorial Drive
CEO City and Zip Code:	Alton, IL 62002
CEO Telephone Number:	618/463-7311

Type of Ownership of Applicants

- [X] Non-profit Corporation
- [ ] For-profit Corporation
- [ ] Limited Liability Company
- [ ] Partnership
- [ ] Governmental
- [ ] Sole Proprietorship
- [ ] Other

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
- Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact [Person to receive ALL correspondence or inquiries]

Name:	Jacob M. Axel
Title:	President
Company Name:	Axel & Associates, Inc.
Address:	675 North Court, Suite 210 Palatine, IL 60067
Telephone Number:	847/776-7101
E-mail Address:	jacobmaxel@msn.com
Fax Number:	847/776-7004

Additional Contact [Person who is also authorized to discuss the application for exemption permit]

Name:	none
Title:	
Company Name:	
Address:	
Telephone Number:	
E-mail Address:	
Fax Number:	

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR EXEMPTION PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Alton Memorial Hospital
Street Address:	One Memorial Drive
City and Zip Code:	Alton, IL 62002
County: Madison	Health Service Area 11 Health Planning Area: F-01

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name:	BJC Health System d/b/a BJC HealthCare
Street Address:	4901 Forest Park Avenue Suite 1200
City and Zip Code:	St. Louis, MO 63108
Name of Registered Agent:	CSC-Lawyers Incorporating Service Company
Registered Agent Street Address:	221 Bolivar Street
Registered Agent City and Zip Code:	Jefferson City, MO 65101
Name of Chief Executive Officer:	Steven H. Lipstein
CEO Street Address:	4901 Forest Park Avenue Suite 1200
CEO City and Zip Code:	St. Louis, MO 63108
CEO Telephone Number:	314/286-2030

Type of Ownership of Applicants

X Non-profit Corporation ☐ Partnership
☐ For-profit Corporation ☐ Governmental
☐ Limited Liability Company ☐ Sole Proprietorship ☐ Other

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
- Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact [Person to receive ALL correspondence or inquiries]

Name:	Jacob M. Axel
Title:	President
Company Name:	Axel & Associates, Inc.
Address:	675 North Court, Suite 210 Palatine, IL 60067
Telephone Number:	847/776-7101
E-mail Address:	jacobmaxel@msn.com
Fax Number:	847/776-7004

Additional Contact [Person who is also authorized to discuss the application for exemption permit]

Name:	none
Title:	
Company Name:	
Address:	
Telephone Number:	
E-mail Address:	
Fax Number:	

Post Exemption Permit Contact

[Person to receive all correspondence subsequent to permit issuance-**THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960]**

Name:	David Braasch
Title:	President
Company Name:	Alton Memorial Hospital
Address:	One Memorial Drive Alton, IL 62002
Telephone Number:	618/463-7311
E-mail Address:	David.Braasch@bjc.org
Fax Number:	

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Alton Memorial Hospital

Address of Site Owner: One Memorial Drive Alton, IL 62002

Street Address or Legal Description of the Site: One Memorial Drive Alton, IL 62002

Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.

APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

[Provide this information for each applicable facility and insert after this page.]

Exact Legal Name: Alton Memorial Hospital

Address: One Memorial Drive Alton, IL 62002

X	Non-profit Corporation	☐	Partnership		
☐	For-profit Corporation	☐	Governmental		
☐	Limited Liability Company	☐	Sole Proprietorship	☐	Other

- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.
- **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**

APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Organizational Relationships

Provide (for each applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

APPEND DOCUMENTATION AS ATTACHMENT 4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2006-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements, please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at **www.FEMA.gov** or **www.illinoisfloodmaps.org**. **This map must be in a readable format**. In addition, please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2006-5 **(http://** www.illinois.gov/sites/hfsrb**)**.

APPEND DOCUMENTATION AS ATTACHMENT 5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

APPEND DOCUMENTATION AS ATTACHMENT 6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

DESCRIPTION OF PROJECT

1. Project Classification

[Check those applicable - refer to Part 1110.40 and Part 1120.20(b)]

Part 1110 Classification:

☐ Change of Ownership

X Discontinuation of an Existing Health Care Facility or of a category of service

☐ Establishment or expansion of a neonatal intensive care or beds

2. Narrative Description

In the space below, provide a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms**, **NOT WHY** it is being done. If the project site does NOT have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

The applicants propose to discontinue Alton Memorial Hospital's long term care category of service, which includes twenty-eight authorized beds.

This is a substantive project because it involves and is limited to the discontinuation of a category of service.

Project Costs and Sources of Funds (Neonatal Intensive Care Services only)

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must be equal.

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	$0	$0	$0
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	$0	$0	$0

NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Related Project Costs

Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

Land acquisition is related to project ☐ Yes X No
Purchase Price: $_____
Fair Market Value: $_____

The project involves the establishment of a new facility or a new category of service
☐ Yes X No

If yes, provide the dollar amount of all **non-capitalized** operating start-up costs (including operating deficits through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.

Estimated start-up costs and operating deficit cost is $ _____.

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.

Indicate the stage of the project's architectural drawings:

X None or not applicable ☐ Preliminary

☐ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): _within 60 days following approval_

Indicate the following with respect to project expenditures or to financial commitments (refer to Part 1130.140):

☐ Purchase orders, leases or contracts pertaining to the project have been executed.
☐ Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies
☐ Financial Commitment will occur after permit issuance.

APPEND DOCUMENTATION AS ATTACHMENT 8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable:
X Cancer Registry
X APORS
X All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
X All reports regarding outstanding permits
Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of _Alton Memorial Hospital_*in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

DAVID BRAASCH
PRINTED NAME

PRESIDENT
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 22 day of December

Signature of Notary

Seal

JENNIFER BAIN
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
November 17, 2020

SIGNATURE

STEPHEN THOMPSON
PRINTED NAME

Chairman
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 22 day of December

Jennifer Bain
Signature of Notary

Seal

JENNIFER BAIN
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
November 17, 2020

*Insert the EXACT legal name of the applicant

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of _BJC Health System d/b/a BJC HealthCare_* in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

Robert T. Lickweg

PRINTED NAME

Pres. BJC

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 21st day of December, 2017

Signature of Notary

Seal

DAPHNE L. WILCUT
Notary Public - Notary Seal
State of Missouri
Commissioned for St. Louis City
My Commission Expires: February 21, 2019
Commission Number: 15146250

SIGNATURE

David R. Applington

PRINTED NAME

Secretary

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 21st day of December, 2017

Signature of Notary

Seal

DAPHNE L. WILCUT
Notary Public - Notary Seal
State of Missouri
Commissioned for St. Louis City
My Commission Expires: February 21, 2019
Commission Number: 15146250

*Insert the EXACT legal name of the applicant

SECTION II. DISCONTINUATION

This Section is applicable to the discontinuation of a health care facility maintained by a State agency. **NOTE:** If the project is solely for discontinuation and if there is no project cost, the remaining Sections of the application are not applicable.

Type of Discontinuation

☐	Discontinuation of an Existing Health Care Facility
X	Discontinuation of a category of service

Criterion 1110.130 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any, that are to be discontinued.
2. Identify all of the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.
6. For applications involving the discontinuation of an entire facility, provide certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 90 days following the date of discontinuation.
7. Upon a finding that an application to close a health care facility is complete, the State Board shall publish a legal notice on 3 consecutive days in a newspaper of general circulation in the area or community to be affected and afford the public an opportunity to request a hearing. If the application is for a facility located in a Metropolitan Statistical Area, an additional legal notice shall be published in a newspaper of limited circulation, if one exists, in the area in which the facility is located. If the newspaper of limited circulation is published on a daily basis, the additional legal notice shall be published on 3 consecutive days. The legal notice shall also be posted on the Health Facilities and Services Review Board's web site and sent to the State Representative and State Senator of the district in which the health care facility is located. In addition, the health care facility shall provide notice of closure to the local media that the health care facility would routinely notify about facility events.
8. Provide attestation that the facility provided the required notice of the facility or category of service closure to local media that the health care facility would routinely notify about facility events. The supporting documentation shall include a copy of the notice, the name of the local media outlet, the date the notice was given, and the result of the notice, e.g., number of times broadcasted, written, or published. Only notice that is given to a local television station, local radio station, or local newspaper will be accepted.

REASONS FOR DISCONTINUATION

The applicant shall state the reasons for the discontinuation and provide data that verifies the need for the proposed action. See criterion 1110.130(b) for examples.

IMPACT ON ACCESS

1. Document that the discontinuation of each service or of the entire facility and whether or not it will have an adverse effect upon access to care for residents of the facility's market area.

2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within 45 minutes travel time of the applicant facility.

APPEND DOCUMENTATION AS ATTACHMENT 10, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION III. BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES - INFORMATION REQUIREMENTS

Not Applicable

This Section is applicable to all projects except those that are solely for discontinuation with no project costs.

Background

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.
3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information was previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS ATTACHMENT 11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

Criterion 1110.230 – Purpose of the Project, and Alternatives (Not applicable to Change of Ownership)

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other relevant area, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed as applicable and appropriate for the project.
4. Cite the sources of the documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals **as appropriate**.

For projects involving modernization, describe the conditions being upgraded, if any. For facility projects, include statements of the age and condition of the project site, as well as regulatory citations, if any. For equipment being replaced, include repair and maintenance records.

NOTE: Information regarding the "Purpose of the Project" will be included in the State Board Report.
APPEND DOCUMENTATION AS ATTACHMENT 12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

ALTERNATIVES

1) Identify **ALL** of the alternatives to the proposed project:

Alternative options **must** include:

A) Proposing a project of greater or lesser scope and cost;

B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;

C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and

D) Provide the reasons why the chosen alternative was selected.

2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short-term (within one to three years after project completion) and long-term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED, THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**

3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

APPEND DOCUMENTATION AS ATTACHMENT 13, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VII. 1120.130 - FINANCIAL VIABILITY

All the applicants and co-applicants shall be identified, specifying their roles in the project funding or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

Not Applicable—No Project Cost

Financial Viability Waiver

The applicant is not required to submit financial viability ratios if:

1. "A" Bond rating or better
2. All of the projects capital expenditures are completely funded through internal sources
3. The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent
4. The applicant provides a third party surety bond or performance bond letter of credit from an A rated guarantor.

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT 17, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which **audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion.** When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.

	Historical 3 Years			Projected
Enter Historical and/or Projected Years:				
Current Ratio				
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each.

2. Variance

Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default.

APPEND DOCUMENTATION AS ATTACHMENT 18, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VIII. 1120.140 - ECONOMIC FEASIBILITY

Not Applicable—No Project Cost

This section is applicable to all projects subject to Part 1120.

A. Reasonableness of Financing Arrangements

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or

2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:

   A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or

   B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

1) That the selected form of debt financing for the project will be at the lowest net cost available;

2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;

3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

1. Identify each department or area impacted by the proposed project and provide a cost and square footage allocation for new construction and/or modernization using the following format (insert after this page).

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Mod.	Gross Sq. Ft. New Circ.*		Gross Sq. Ft. Mod. Circ.*		Const. $ (A x C)	Mod. $ (B x E)	
Contingency									
TOTALS									
* Include the percentage (%) of space for circulation									

D. Projected Operating Costs

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

E. Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

APPEND DOCUMENTATION AS ATTACHMENT 19, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IX. SAFETY NET IMPACT STATEMENT (DISCONTINUATION ONLY)

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE PROJECTS AND PROJECTS TO DISCONTINUE STATE-OWNED HEALTH CARE FACILITIES [20 ILCS 3960/5.4]:

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.

2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.

3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all of the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.

3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 40.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			
Charity (cost In dollars)			
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			
Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

APPEND DOCUMENTATION AS ATTACHMENT 20, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

ALTON MEMORIAL HOSPITAL

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**2014**	**2015**	**2016**
Inpatient	342	276	280
Outpatient	3,973	3,517	4,420
Total	**4,315**	**3,793**	**4,700**
Charity (cost In dollars)			
Inpatient			
Outpatient			
Total	**$770,975**	**$996,722**	**$1,128,172**
MEDICAID			
Medicaid (# of patients)	**2014**	**2015**	**2016**
Inpatient	1,392	1,620	1,590
Outpatient	26,169	28,855	30,779
Total	27,561	30,475	32,369
Medicaid (revenue)			
Inpatient	$3,577,851	$3,260,534	$3,916,745
Outpatient	$3,663,073	$5,455,868	$6,662,694
Total	$7,240,924	$8,716,402	$10,579,439

MEMORIAL HOSPITAL

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**2014**	**2015**	**2016**
Inpatient	969	753	916
Outpatient	7,977	6,450	8,568
Total	**8,946**	**7,203**	**9,484**
Charity (cost In dollars)			
Inpatient			
Outpatient			
Total	**$2,514,817**	**$1,547,666**	**$2,333,822**
MEDICAID			
Medicaid (# of patients)	**2014**	**2015**	**2016**
Inpatient	1,717	524	455
Outpatient	25,903	7,808	6,164
Total	27,620	8,332	6,619
Medicaid (revenue)			
Inpatient	$10,409,913	$5,200,611	$8,808,924
Outpatient	$3,473,335	$1,166,637	$7,322,085
Total	$1,388,248	$6,367,248	$16,131,009

MEMORIAL HOSPITAL-EAST

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**2014**	**2015**	**2016**
Inpatient			25
Outpatient			144
Total			**169**
Charity (cost In dollars)			
Inpatient			
Outpatient			
Total			**$9,620,729**
MEDICAID			
Medicaid (# of patients)	**2014**	**2015**	**2016**
Inpatient			117
Outpatient			1,021
Total			1,138
Medicaid (revenue)			
Inpatient			$704,550
Outpatient			$1,152,745
Total			$1,857,295

File Number 2454-784-1

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

ALTON MEMORIAL HOSPITAL, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 08, 1936, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 1ST *day of* NOVEMBER *A.D.* 2017 .

Authentication #: 1730501500 verifiable until 11/01/2018
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

ATTACHMENT 1

STATE OF MISSOURI

Jason Kander
Secretary of State

CORPORATION DIVISION
CERTIFICATE OF GOOD STANDING

I, JASON KANDER, Secretary of State of the State of Missouri, do hereby certify that the records in my office and in my care and custody reveal that

BJC HEALTH SYSTEM
N00045883

was created under the laws of this State on the 11th day of May, 1992, and is in good standing, having fully complied with all requirements of this office.

IN TESTIMONY WHEREOF, I hereunto set my hand and cause to be affixed the GREAT SEAL of the State of Missouri. Done at the City of Jefferson, this 13th day of May, 2015.

Jason Kander
Secretary of State

Certification Number: CERT-05132015-0078

ATTACHMENT F

BJC HealthCare

SITE OWNERSHIP

December 21, 2017

Illinois Health Facilities
and Services Review Board
Springfield, Illinois

To Whom It May Concern:
Please be advised that Alton Memorial Hospital's site is owned by Alton Memorial Hospital, a subsidiary of BJC Health System.

Sincerely,

Greg Bratcher
Director, Policy Analysis
BJC Healthcare

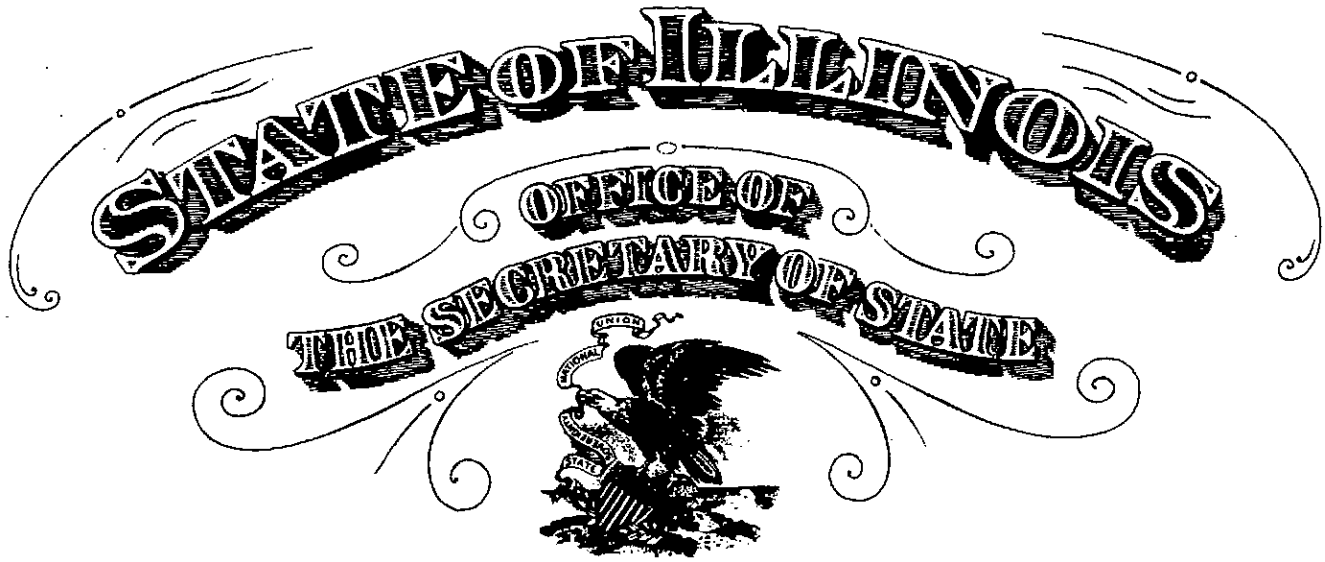
Notarized: Daphne L. Wilcut

DAPHNE L. WILCUT
Notary Public - Notary Seal
State of Missouri
Commissioned for St. Louis City
My Commission Expires: February 21, 2019
Commission Number: 15146250

expires 2/21/2019

ATTACHMENT 2

File Number 2454-784-1



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

ALTON MEMORIAL HOSPITAL, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 08, 1936, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

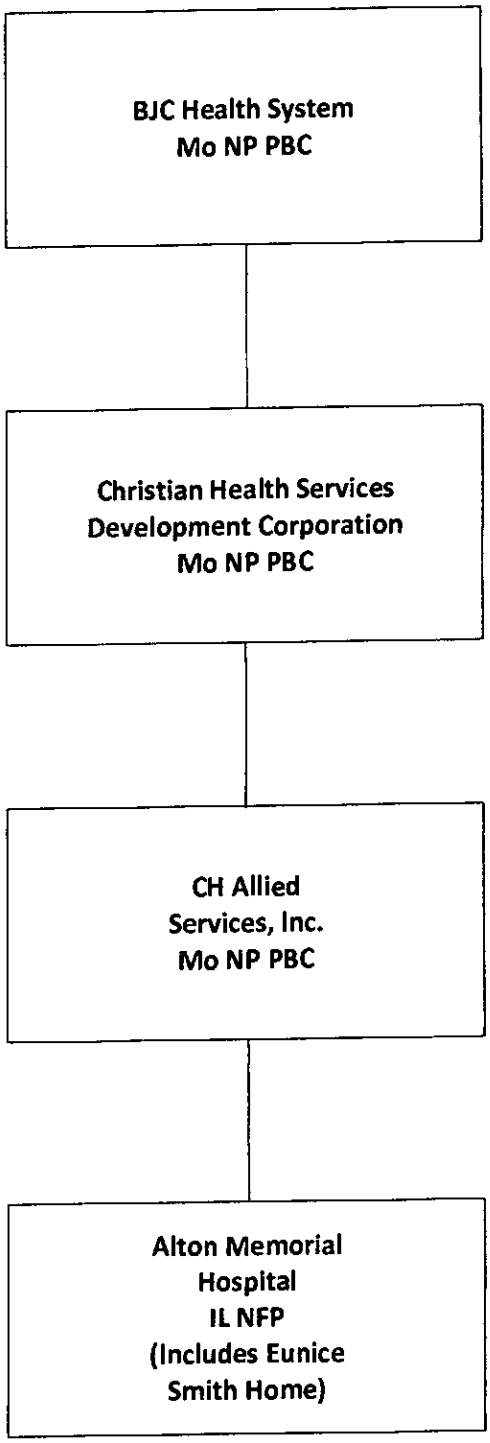
In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 1ST *day of* NOVEMBER *A.D.* 2017 .

Authentication #: 1730501500 verifiable until 11/01/2018
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

ATTACHMENT 3

Alton Memorial Hospital & Eunice Smith Nursing Home Organizational Chart



ATTACHMENT 4

DISCONTINUATION

General Information Requirements

1. Alton Memorial Hospital's inpatient long term care category of service, consisting of twenty-eight (28) beds will be discontinued.

2. No other clinical services will be discontinued as a result of the Certificate of Exemption ("COE") sought through this application.

3. Alton Memorial Hospital has notified the IHFSRB of a "suspension" of the long term care program, with the last patient being discharged on or about December 10, 2017. Discontinuation, in the form of filing proper documentation with the IHFSRB will occur within thirty days of the COE's approval.

4. A decision of the future use of the 28-bed nursing unit has yet to be made. Among the potential uses under consideration is the conversion of the unit to a Medical/Surgical unit, which, if selected, would be done consistent with IHFSRB and IDPH requirements.

5. Medical records and other pertinent information relating to services provided to patients on the long term care unit will be retained by Alton Memorial Hospital, consistent with its records retention and maintenance policies.

6. The proposed project is limited to the discontinuation of a single category of service, and therefore criterion 1110.130.a)6 is not applicable.

7. It is anticipated that the State Board will publish appropriate legal notices relating to the proposed discontinuation.

8. With the filing of this application, the applicants attest that the required notice of the anticipated category of service discontinuation was published on December 13-15, 2017 in The Telegraph, a newspaper of general distribution serving the Alton, Illinois area (copy attached).

Reason for Discontinuation

The primary reasons for the proposed discontinuation are: 1) a low census, and 2) high quality alternatives.

During the period January 1, 2013 through December 31, 2016 the hospital's 28-bed long term care unit operated with an average daily census of 11.8 patients and an associated occupancy rate of 42.3%. During 2016, the peak census on the unit was only 15 patients. An occupancy rate as low as that experienced in recent years creates staffing difficulties, and with the increasing utilization of outpatient post-operative therapy for orthopedic patients, utilization of the unit is anticipated to decrease further.

As identified in the section below, there are numerous providers of long term care services in the area, and the hospital's discharge planning department has not experienced significant difficulties with the placement of patients. Paramount among the reasonable alternatives is Eunice C. Smith Nursing Home, which located adjacent to and controlled by Alton Memorial Hospital.

Impact on Access

The proposed discontinuation of inpatient long term care services at Alton Memorial Hospital will have no substantial impact on the ability of residents of the hospital's service area to access care.

Currently, the skilled care (22+) occupancy rate in Madison County is only 68%. And, there are nineteen providers of inpatient long term care located within 45 minutes travel time of Alton Memorial Hospital, three of which are located in Alton. Therefore, the proposed

discontinuation will not have a material impact of area residents' ability to access skilled care services.

Letters, consistent with the requirements of Section 1110.130.c were sent to each of those hospitals on November 17, 2017.

Confirmation of receipt and the single response to those letters received prior to this COE application's filing are attached, and a listing of the long term care facilities and hospitals providing long term care services is provided below.

- Eunice C. Smith Nursing Home, Alton
- Rosewood Care Center of Alton, Alton
- Integrity Healthcare of Alton, Alton
- Integrity Healthcare of Godfrey, Godfrey
- Gateway Regional Medical Center, Granite City
- Granite Nursing and Rehabilitation Center, Granite City
- Stearns Nursing and Rehabilitation Center, Granite City
- Integrity Healthcare of Wood River, Wood River
- Bethalto Care Center, Bethalto
- Jerseyville Nursing and Rehabilitation Center, Jerseyville
- Jerseyville Manor, Jerseyville
- Willow Rose Rehabilitation and Health Care, Jerseyville
- Robings Manor Rehabilitation and Health Care, Brighton
- Manor Court of Maryville, Maryville
- Meridian Village, Glen Carbon
- Rosewood Care, Edwardsville
- University Nursing and Rehabilitation, Edwardsville
- Eden Village Care Center, Glen Carbon
- Edwardsville Nursing and Rehabilitation, Edwardsville

There are 2,216 licensed nursing care beds in Madison County. During 2016, the occupancy rate of those beds was 68.0%, confirming that the proposed discontinuation of 28 long term care beds at Alton Memorial Hospital will not result in a negative impact on access to services.

CLASSIFIEDS

LEGALS

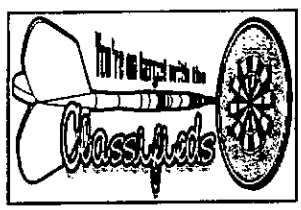
17-0872

Alton Memorial Hospital, in Alton, Ill., intends to close its 28-bed long-term-care unit upon approval of the Illinois Health Facilities and Services Review Board ("IHFSRB"). The discontinuation will occur prior to February 28, 2018. The hospital intends to file the required Certificate of Exemption application with the IHFSRB by January 31, 2018. This application, as well as information concerning the proposed discontinuation, can be found on the IHFSRB website at: hfsrb.illinois.gov. If you have any questions or concerns, please direct them to Greg Bratcher, 4901 Forest Park Ave., MS 90-75-574, St. Louis, MO 63108.

Personals

Miscellaneous

Auctions



Attorney

FINANCIAL SERVICES

LEGALS

17-0876

NOTICE OF RESOLUTION DETERMINING TO LEVY AN ADDITIONAL .02% LIBERTY TAX

RESOLUTION NO. 1847

A RESOLUTION DETERMINING TO LEVY AN ADDITIONAL .02% LIBRARY TAX

WHEREAS, the City Council has received a formal resolution from the Wood River Library Board of Directors requesting the levy of an additional tax of .02% for repairs and alterations of their building in the amount of $18,000.00; and

WHEREAS, Chapter 75 ILCS 5/2-1 provides that the City Council shall adopt a resolution determining to levy such tax, if desired.

NOW, THEREFORE, BE IT RESOLVED BY THE CITY COUNCIL OF THE CITY OF WOOD RIVER, IL, as follows:

Section 1. The City of Wood River has determined the need to levy an additional tax of .02% of the value of all the taxable property in the City, as equalized or assessed by the Department of Revenue, for the purchase of sites and buildings, for the construction and equipment of buildings, for the rental of buildings required for library purposes, and for maintenance, repairs and alterations of library buildings and equipment.

Section 2. Upon passage and approval, this resolution will be published, as required by Law.

PASSED and APPROVED this 13th day of December, 2017 by the City Council of the City of Wood River.

Cheryl Maguire
MAYOR OF THE CITY OF WOOD RIVER

ATTEST:
Jan Sneed
CLERK OF THE CITY OF WOOD RIVER

EMPLOYMENT

THE CLASSIFIEDS

LEGALS

17-0877A

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HABITAT FOI

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AND NON RECO

No. 16-

AMENDED NOTICE OF JUDGMENT OF UNDER ILLINOIS MORT AC

PUBLIC NOTICE IS HEI
ant to a Judgment of Fore
by said Court in the abo
gust 31, 2017, Judge Hai
in his stead, in Madisor
January 11, 2018 in the
foreclosures on the day
Courthouse, 155 N. Ma
Illinois, at 1:00 p.m., sell
to the highest bidder for
and singular, the followi
mentioned in said Juc
County of Madison, Sta
thereof as shall be suffic
ment,

Lots Numbered Seven
and the East one half of
rung Heights a subdivisi
from plat recorded in t
Madison County, Illinois
situated in the City of A
and State

Parcel Identific
23-2-07-11-

Commonly known as: 22
62

ATTACHMENT 10

BETHALTO CARE CENTER, INC.

Committment to Caring

815 South Prairie
Bethalto, Illinois 62010
Phone (618) 377-2144
Fax (618) 377-3349

Linda M. Daniels
President / Administrator

Nicholaus T. Daniels
Management

11/21/17

Alton Memorial Hospital
#1 Memorial Dr.
Alton, IL 62002

Attention: David A. Braach, President

Bethalto Care Center, Inc. is a privately owned Nursing Home. The Owner, Linda Daniels is also the Administrator.

Bethalto Care Center, Inc. cares for Intermediate Nursing residents. We do no feeding tubes, IV's, Formal Therapies or Intense Complicated Wound Care.

Bethalto Care Center, Inc. has Restorative Nursing providing AROM, PROM, Ambulation and Transfer Training, Wheelchair Training and Walker Training etc.

Our care specifically accommodates resident who have completed their Medicare days and are unable to advance any further.

We accept privately funded residents and Medicaid residents as well as Medicaid pending case by case.

We have been fortunate enough to work with Eunice Smith Nursing Home and Rosewood Care Center placing resident transitioning from Medicare Unit to Intermediate Care.

Thank you for your consideration.

Respectfully,

Linda Daniels

Linda Daniels, Owner/Administrator, Bethalto Care Center, Inc.

ATTACHMENT 10

■ Complete Items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
■ Print your name and address on the reverse so that we can return the card to you.
■ Attach this card to the back of the mailpiece, or on the front if space permits.

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Amanda Vayles ☐ Agent ☐ Addressee

B. Received by (Printed Name) Amanda Vayles
C. Date of Delivery 11-20-17

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

1. Article Addressed to:
Integrity Healthcare - of Wood River
343 Edwardsville Rd.
Wood River, IL 62095

3. Service Type
☒ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7013 2250 0001 4898 6112

PS Form 3811, July 2013 Domestic Return Receipt

■ Complete Items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
■ Print your name and address on the reverse so that we can return the card to you.
■ Attach this card to the back of the mailpiece, or on the front if space permits.

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

1. Article Addressed to:
Integrity Healthcare of Godfrey
1623 West Delmar
Godfrey, IL 62035

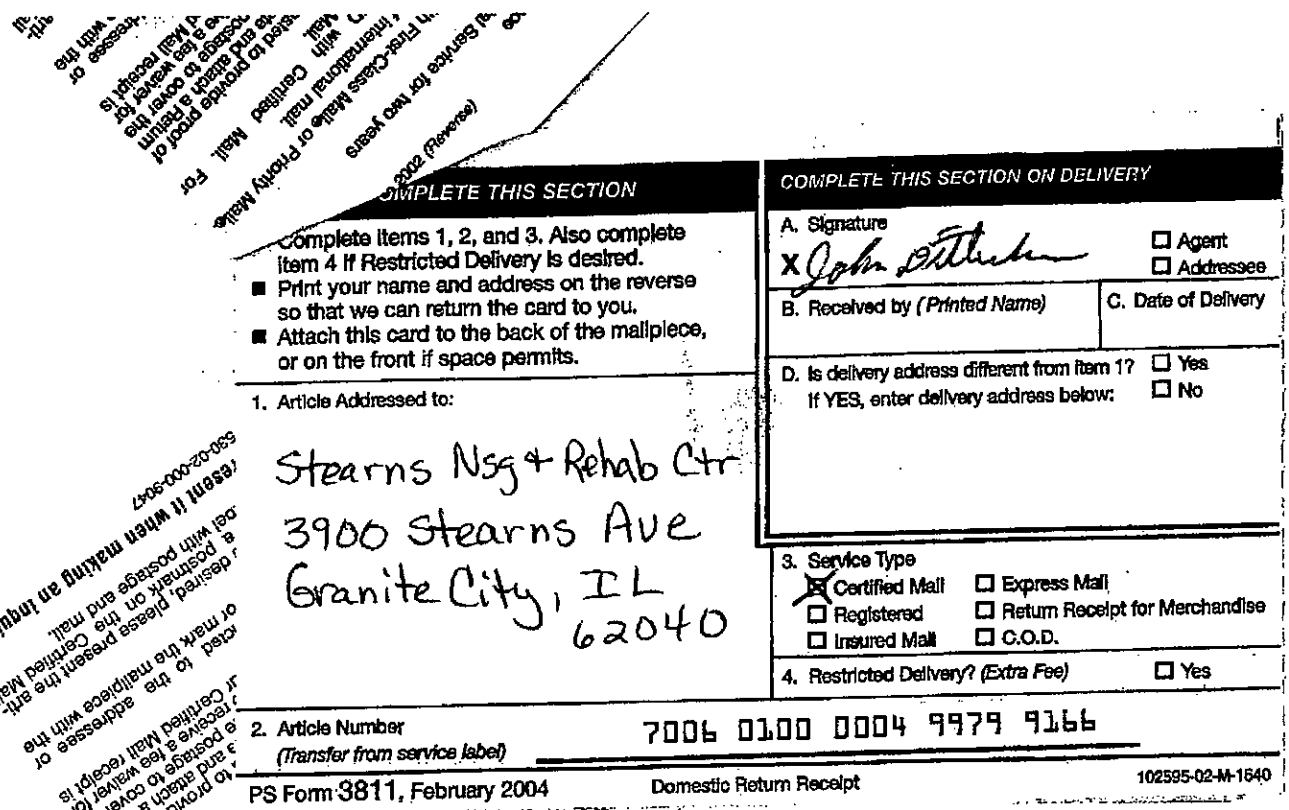
3. Service Type
☒ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7009 0820 0000 7964 3814

PS Form 3811, July 2013 Domestic Return Receipt

ATTACHMENT 10



COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Stearns Nsg & Rehab Ctr
3900 Stearns Ave
Granite City, IL
62040

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X John Stearns
☐ Agent
☐ Addressee

B. Received by (Printed Name) | C. Date of Delivery

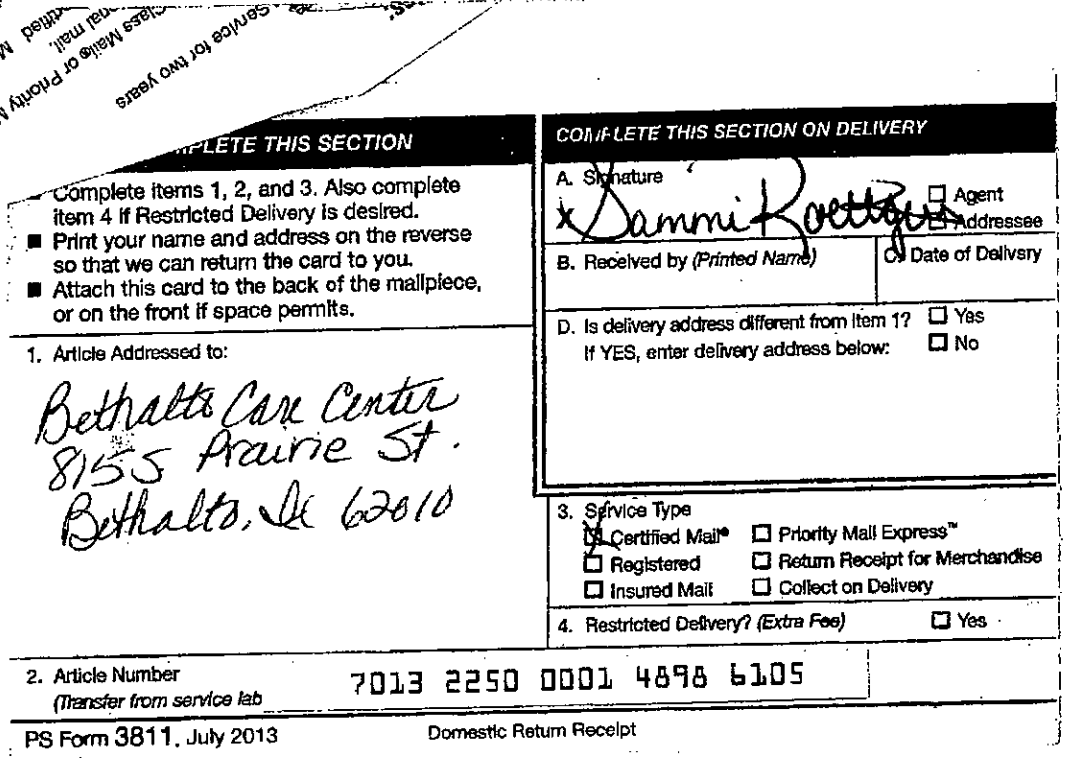
D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7006 0100 0004 9979 9166

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540



COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Bethalto Care Center
8155 Prairie St.
Bethalto, IL 62010

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Sammi Roettger
☐ Agent
☐ Addressee

B. Received by (Printed Name) | C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service lab 7013 2250 0001 4898 6105

PS Form 3811, July 2013 Domestic Return Receipt

ATTACHMENT 10

SECTION

COMPLETE THIS SECTION ON DELIVERY

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so thet we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

A. Signature
X Sharon Tranter ☐ Agent ☐ Addressee

B. Received by (Printed Name) Sharon Tranter
C. Date of Delivery 11-21-17

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☒ No

1. Article Addressed to:
Robings Manor RHA
502 No. Main
Brighton, IL 62012

Robox 787

3. Service Type
☒ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7013 2250 0001 4898 6075

PS Form 3811, July 2013 Domestic Return Receipt

LETE THIS SECTION

COMPLETE THIS SECTION ON DELIVERY

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

A. Signature
X J. C. Cavaran ☐ Agent ☐ Addressee

B. Received by (Printed Name)
C. Date of Delivery 11-20-17

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

1. Article Addressed to:
Jerseyville Manor
1251 N. State St.
Jerseyville, IL 62052

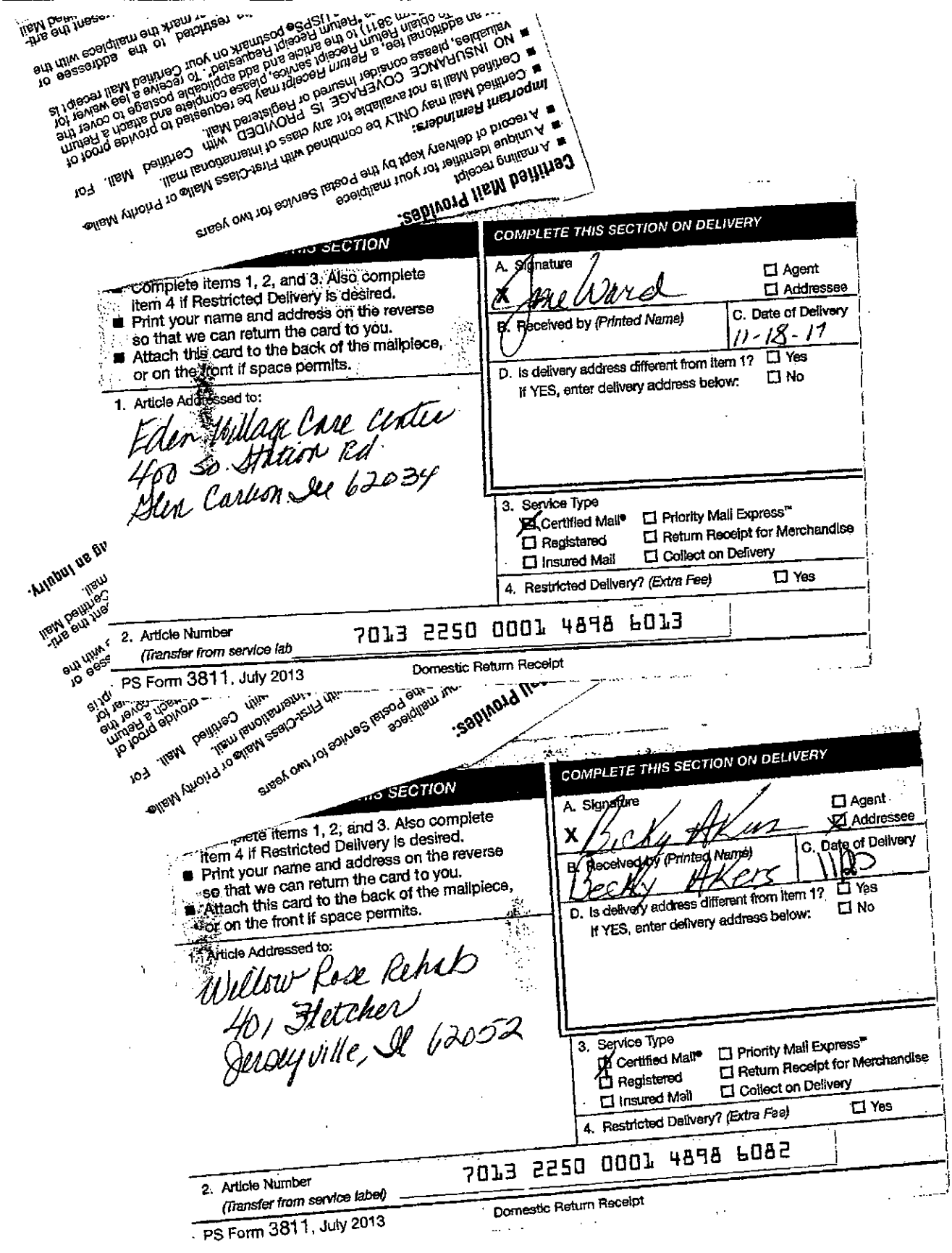
3. Service Type
☒ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7013 2250 0001 4898 6099

PS Form 3811, July 2013 Domestic Return Receipt

ATTACHMENT 10



SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Eden Village Care Center
400 So. Station Rd.
Glen Carbon, Ill 62034

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Jane Ward ☐ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery
11-18-17

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service lab) 7013 2250 0001 4898 6013

PS Form 3811, July 2013 Domestic Return Receipt

Certified Mail Provides:
- A mailing receipt
- A unique identifier for your mailpiece
- A record of delivery kept by the Postal Service for two years

Important Reminders:
- Certified Mail may ONLY be combined with First-Class Mail® or Priority Mail®.
- Certified Mail is not available for any class of international mail.
- NO INSURANCE COVERAGE IS PROVIDED with Certified Mail. For valuables, please consider Insured or Registered Mail.
- Certified Mail may be requested to provide proof of delivery. To obtain Return Receipt service, please complete and attach a Return Receipt (PS Form 3811) to the article and add applicable postage to cover the fee. Return Receipt service includes delivery information.
- To receive a fee waiver for an additional copy of your Certified Mail receipt, go to USPS® postmark on your Certified Mail receipt.
- To receive a fee waiver for an additional copy of your Certified Mail receipt, go to USPS® postmark on your Certified Mail receipt.

SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Willow Rose Rehab
401 Fletcher
Jerseyville, Il 62052

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Becky Akers ☐ Agent ☒ Addressee

B. Received by (Printed Name) Becky Akers C. Date of Delivery 11/20

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

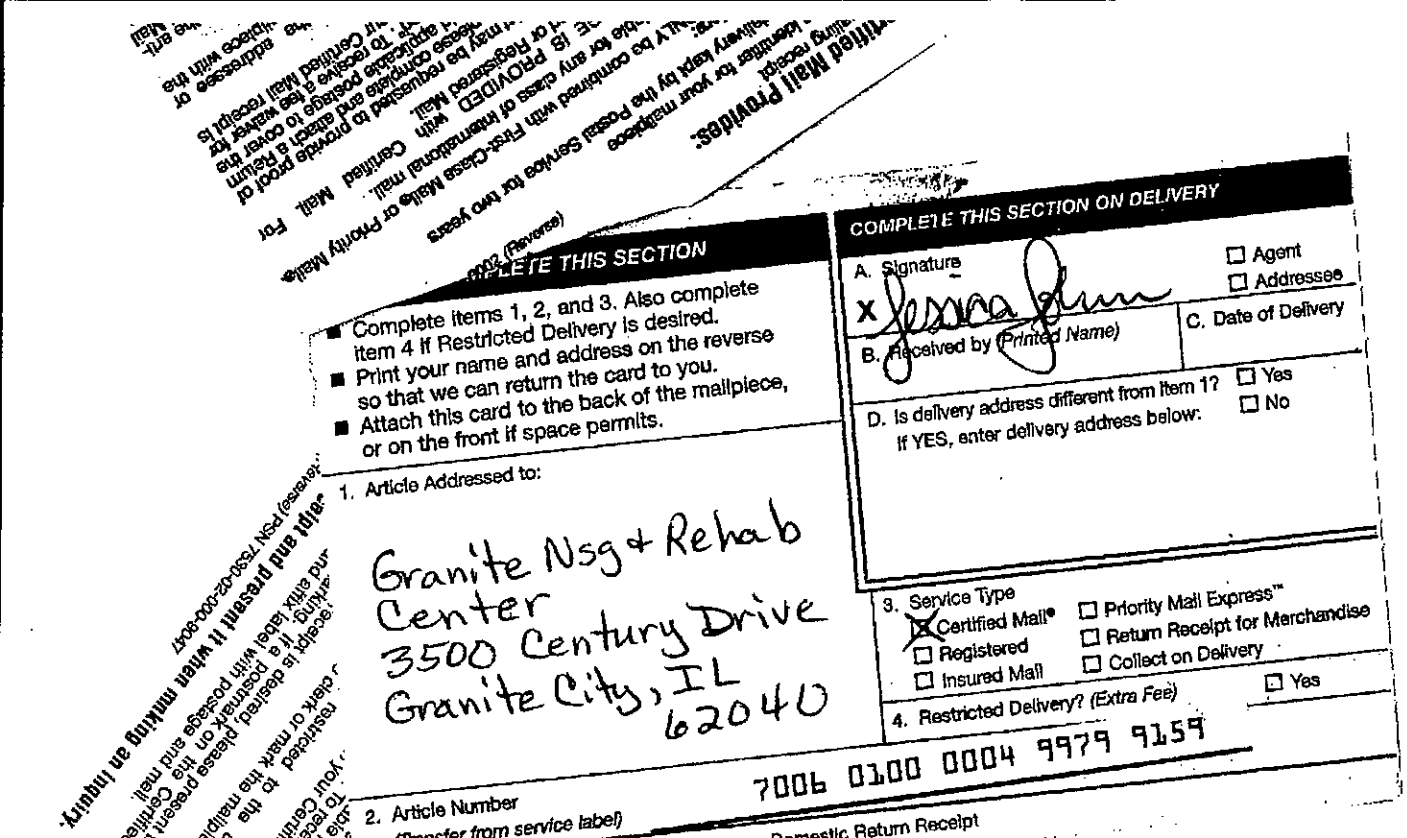
3. Service Type
☒ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7013 2250 0001 4898 6082

PS Form 3811, July 2013 Domestic Return Receipt

ATTACHMENT 10



SECTION 1 (Reverse)

COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Granite Nsg & Rehab Center
3500 Century Drive
Granite City, IL
62040

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Jessica Shum
☐ Agent
☐ Addressee

B. Received by (Printed Name)

C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7006 0100 0004 9979 9159

PS Form 3811, July 2013 Domestic Return Receipt

COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Edwardsville Nsg & Rehab
401 St Mary Dr.
Edwardsville, IL
62025

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Tammy Leveling
☐ Agent
☐ Addressee

B. Received by (Printed Name)
Tammy Leveling

C. Date of Delivery
11/20

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

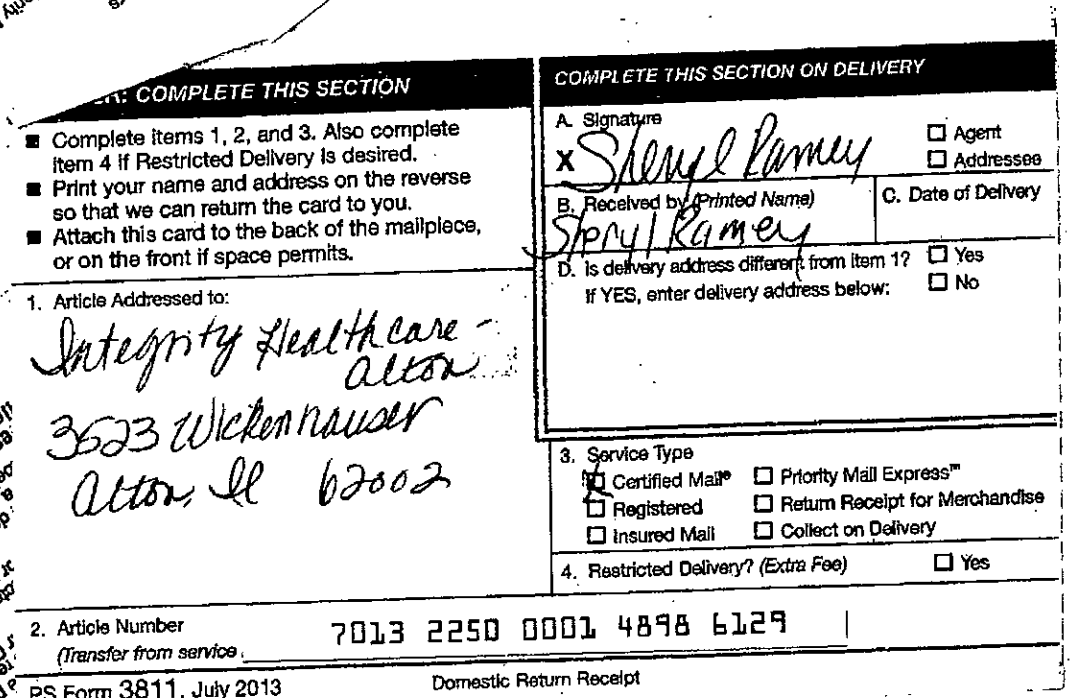
3. Service Type
☒ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7009 0820 0000 7964 3807

PS Form 3811, July 2013 Domestic Return Receipt

ATTACHMENT 10



N: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Integrity Healthcare - Alton
3523 Wickenhauser
Alton, IL 62002

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Sheryl Ramey ☐ Agent ☐ Addressee

B. Received by (Printed Name) Sheryl Ramey
C. Date of Delivery

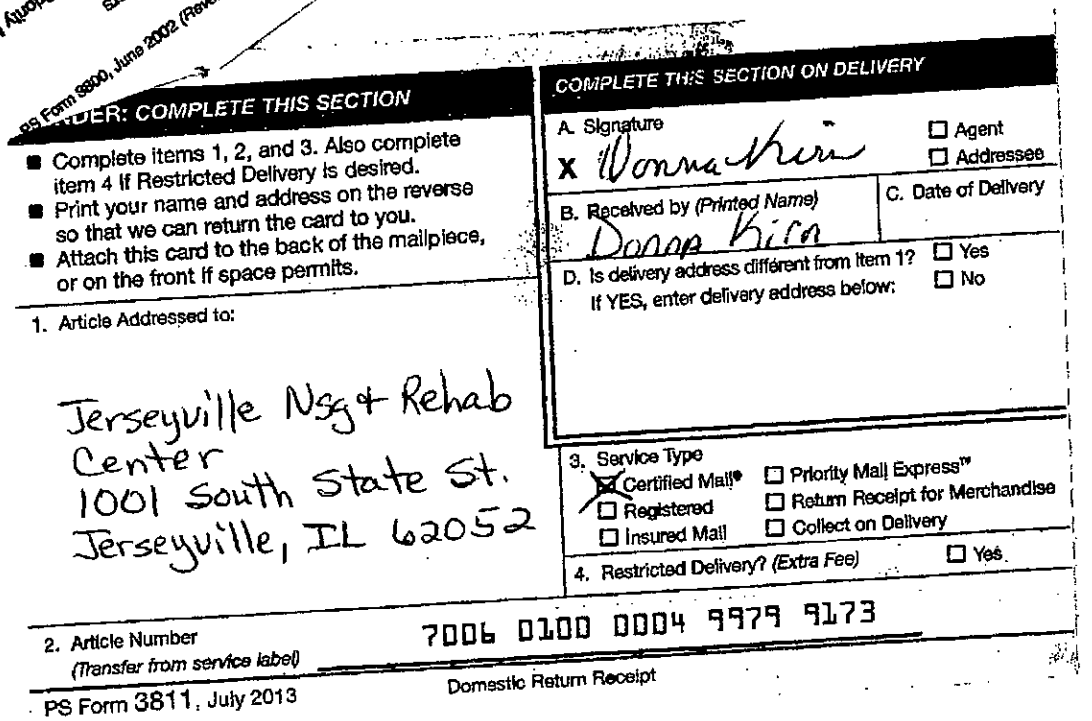
D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7013 2250 0001 4898 6129

PS Form 3811, July 2013 Domestic Return Receipt



DER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Jerseyville Nsg + Rehab Center
1001 South State St.
Jerseyville, IL 62052

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Donna Kirn ☐ Agent ☐ Addressee

B. Received by (Printed Name) Donna Kirn
C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7006 0100 0004 9979 9173

PS Form 3811, July 2013 Domestic Return Receipt

ATTACHMENT 10

items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Gateway Regional Medical Ctr SNF
2100 Madison Ave.
Granite City, IL
62040

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X
☐ Agent
☐ Addressee

B. Received by (Printed Name) Alisha Taylor

C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7006 0100 0004 9979 9142

PS Form 3811, July 2013 Domestic Return Receipt

THIS SECTION

Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Rosewood Care-Edwardsville
6277 Center Grove Rd.
Edwardsville, IL 62025

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X
☐ Agent
☐ Addressee

B. Received by (Printed Name)

C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service la 7013 2250 0001 4898 6037

PS Form 3811, July 2013 Domestic Return Receipt

ATTACHMENT 10

Certified Mail Provides:

- A mailing receipt
- A unique identifier for your mailpiece
- A record of delivery kept by the Postal Service for two years

Important Reminders:

- Certified Mail may ONLY be combined with First-Class Mail® or Priority Mail®.
- Certified Mail is *not* available for any class of international mail.
- NO INSURANCE COVERAGE IS PROVIDED with Certified Mail. For valuables, please consider Insured or Registered Mail.
- For an additional fee, a *Return Receipt* may be requested to provide proof of delivery. To obtain Return Receipt service, please complete and attach a Return Receipt (PS Form 3811) to the article and add applicable postage to cover the fee. Endorse mailpiece "Return Receipt Requested". To receive a fee waiver for a duplicate return receipt, a USPS® postmark on your Certified Mail receipt is required.
- ... an additional fee, delivery may be restricted to the addressee or ...e's authorized agent. Advise the clerk or mark the mailpiece with the ... "Restricted Delivery".
- ... Certified Mail receipt is desired, please present the arti... postmarking. If a postmark on the Certified Mail ... and affix label with postage and mail.

...ent it when making an inquiry.

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Rosewood Care Center - Alton
3490 Humbert Rd.
Alton, IL 62002

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Valery Michaels ☐ Agent ☐ Addressee

B. Received by (*Printed Name*)

C. Date of Delivery 11-20

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (*Extra Fee*) ☐ Yes

2. Article Number (*Transfer from service lab*) 7013 2250 0001 4898 6136

PS Form 3811, July 2013 Domestic Return Receipt

ATTACHMENT 10

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Meridian Village
27 Auerbach Place
Glen Carbon, IL 62034

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Diane Asselmeier ☐ Agent ☐ Addressee

B. Received by (Printed Name) Diane Asselmeier
C. Date of Delivery 12-13-17

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service la 7006 0100 0004 9979 9180

PS Form 3811, July 2013 Domestic Return Receipt

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

University Nursing & Rehab
1095 University Dr.
Edwardsville, IL 62025

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Susan Anderson ☐ Agent ☐ Addressee

B. Received by (Printed Name) Susan Anderson
C. Date of Delivery 12/14/17

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

ATTACH HERE

3. Service Type
☒ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service l 7013 2250 0001 4898 6143

PS Form 3811, July 2013 Domestic Return Receipt

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)
For delivery information visit our website at www.usps.com®
OFFICIAL USE

Postage	$
Certified Fee	
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

Postmark Here 12/11/17

Sent To Meridian Village
Street, Apt. No.; or PO Box No. 27 Auerbach Place
City, State, ZIP+4 Glen Carbon, IL 62034

See Reverse for Instructions
PS Form 3800, June 2002

7006 0100 0004 9979 9180

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)
For delivery information visit our website at www.usps.com®
OFFICIAL USE

Postage	$
Certified Fee	
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

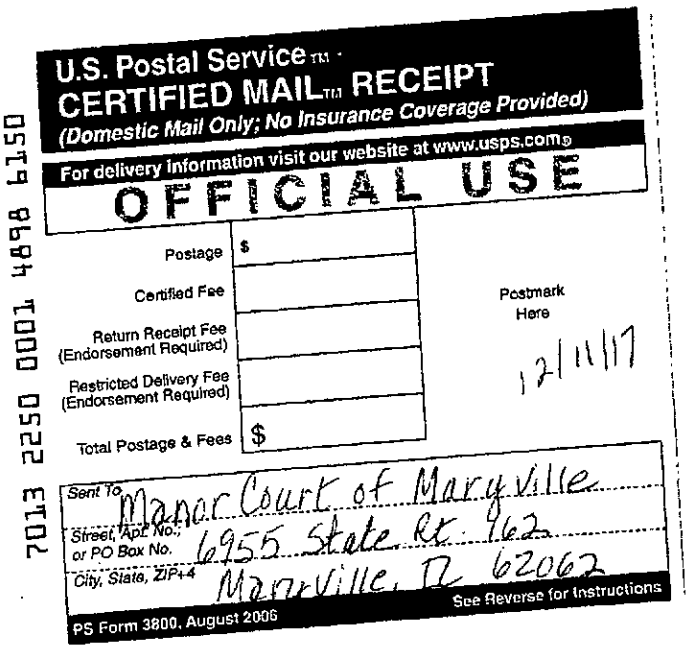
Postmark Here

Sent To University Nursing & Rehab
Street, Apt. No.; or PO Box No. 1095 University Dr.
City, State, ZIP+4 Edwardsville IL 62025

See Reverse for Instructions
PS Form 3800, August 2006

7013 2250 0001 4898 6143

39



U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)
For delivery information visit our website at www.usps.com®
OFFICIAL USE

7013 2250 0001 4898 6150

Postage $
Certified Fee
Return Receipt Fee (Endorsement Required)
Restricted Delivery Fee (Endorsement Required)
Total Postage & Fees $

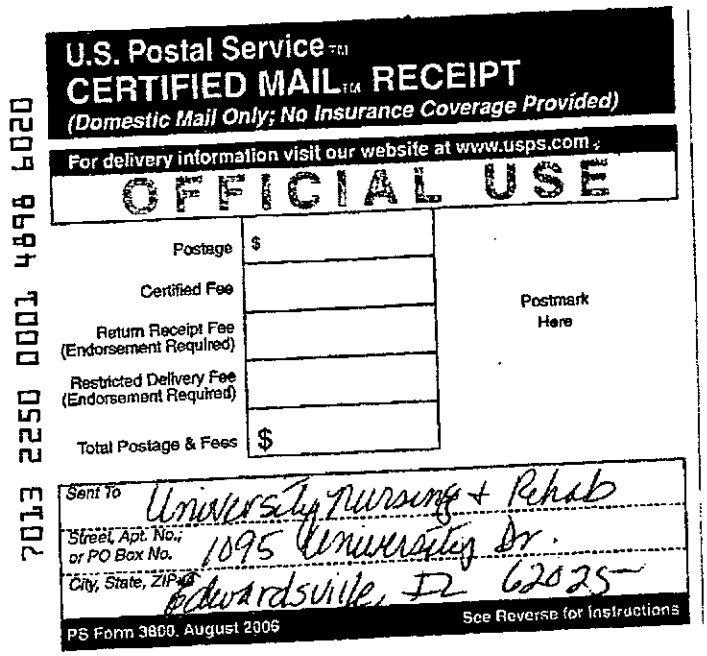
Postmark Here
12/11/17

Sent To: Manor Court of Maryville
Street, Apt. No.; or PO Box No.: 6955 State Rt. 162
City, State, ZIP+4: Maryville, IL 62062

PS Form 3800, August 2006 See Reverse for Instructions

No card returned as of 12/22/17

ATTACHMENT 10



U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)
For delivery information visit our website at www.usps.com®
OFFICIAL USE

7013 2250 0001 4898 6020

Postage	$
Certified Fee	
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

Postmark Here

Sent To: University Nursing + Rehab
Street, Apt. No.; or PO Box No.: 1095 University Dr.
City, State, ZIP+4: Edwardsville, IL 62025

PS Form 3800, August 2006 — See Reverse for Instructions

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)
For delivery information visit our website at www.usps.com®
OFFICIAL USE

7013 2250 0001 4898 6044

Postage	$
Certified Fee	
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

Postmark Here

Sent To: Meridian Village
Street, Apt. No.; or PO Box No.: 399 N. Meridian Rd.
City, State, ZIP+4: Glen Carbon, IL 62034

PS Form 3800, August 2006 — See Reverse for Instructions

ATTACHMENT 10

SAFETY NET IMPACT STATEMENT

Due to the relatively low county-wide long-term care facility occupancy rates, it is not anticipated that the discontinuation of long-term care services at Alton Memorial Hospital will have any substantial or material impact on access to essential safety net services. In addition, and due to the abundance of providers in the area, it is not anticipated that the discontinuation of the 28 authorized long-term care beds at the hospital will have a material impact on any provider, with the probable exception of Eunice C. Smith Nursing Home, which is located on the Alton Memorial Hospital campus and will likely realize a disproportionate share of the patients that have traditionally been admitted to the hospital's long-term care unit.

With the signatures provided on the Certification pages of this application, it is certified that, the cost of charity care provided by Alton Memorial Hospital between January 1, 2014 and December 31, 2016 was $2,895,869.

ATTACHMENT 20